Advancing Accountable Care in NC

Networks of Medical Homes

Overview

- **Vision**
- **Status**
  - **CCNC structure and resources**
  - **Our results**
  - **Other related CMS projects**
- **Next Steps**
- **Important Lessons**

The Goal of Reform: Dr. Berwick's "Triple Aim"

- **Better Care for Individuals**
- **Better Health for Populations**
- **Reduce per Capita Cost**

Over a decade ago, North Carolina's providers, along with the State, launched Community Care of North Carolina - CCNC.

A simple premise: strong primary care and better collaboration and coordinated care will improve health and save money in our Medicaid program.

Many states seek to reduce Medicaid costs through reductions in eligibility, benefits and rates

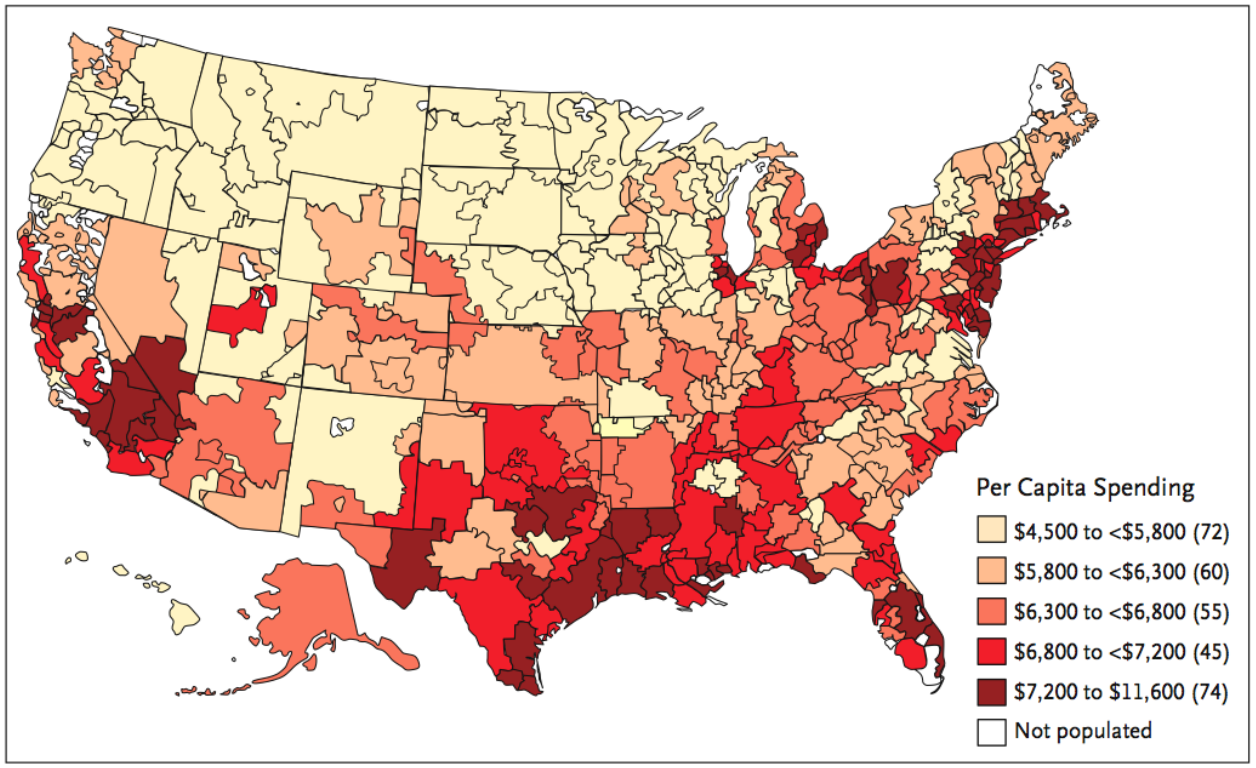
BUT

"Community Care of NC" experience proves costs can be reduced through better quality and coordination without harsh measures

Three Fold Variation in Per Capita Spending

PERSPECTIVE

THE CHALLENGE OF RISING HEALTH CARE COSTS — A VIEW FROM THE CONGRESSIONAL BUDGET OFFICE



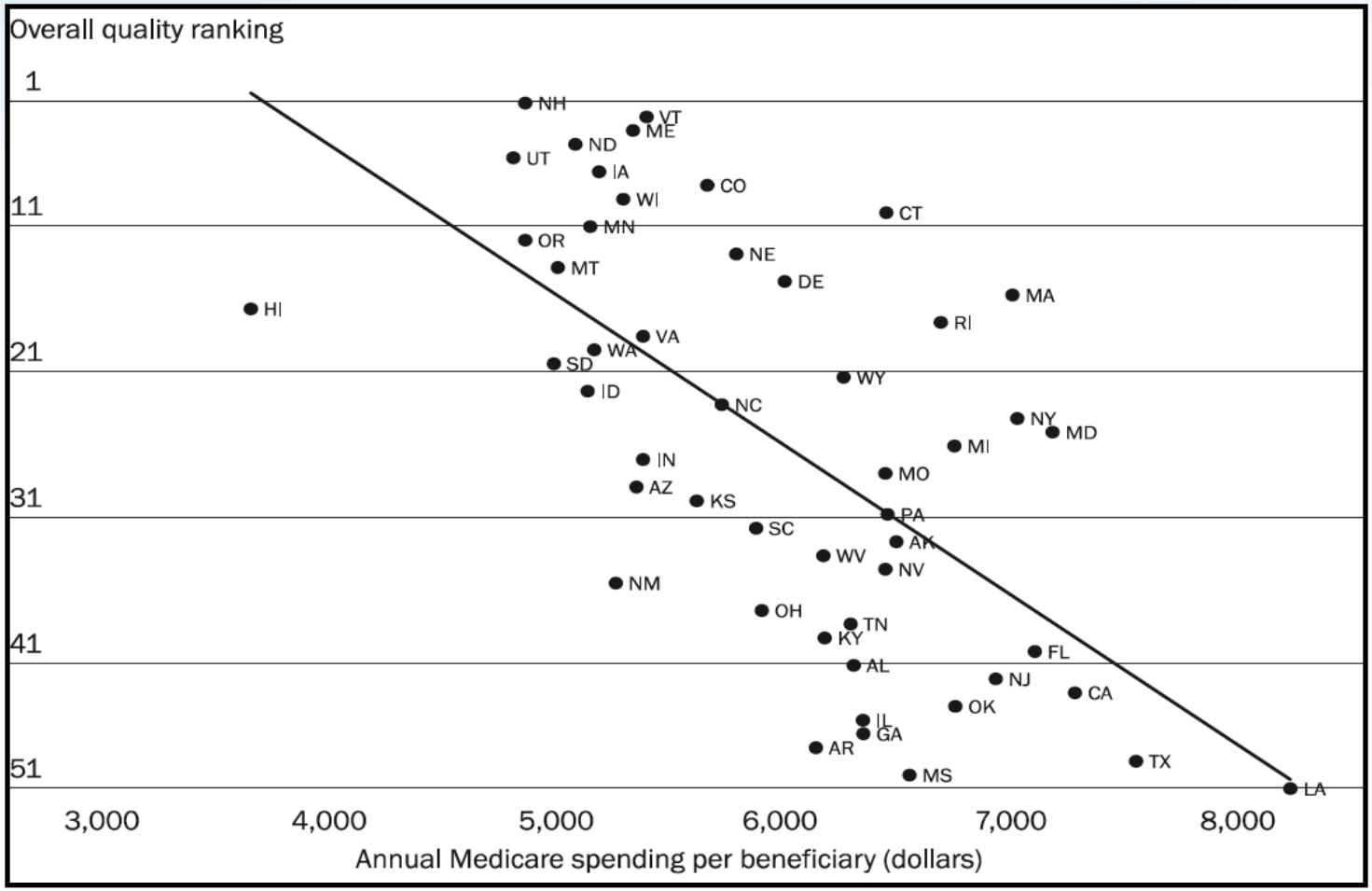
Medicare Spending per Capita, According to Hospital Referral Region, 2003.

Data are from the Dartmouth Atlas of Health Care. Numbers in parentheses are the numbers of hospital referral regions with that level of per capita spending.

Peter Orszag, N Engl J Med, 2007

Higher Healthcare Spending is Not Associated with Better Quality

Community Care of North Carolina



Source: Baicker et al. Health Affairs web exclusives, October 7, 2004

The Changing Metrics of Success

Community Care of North Carolina

- **<u>Current:</u> Volume, Growth, Market Share, Contract Price**
- **<u>Future:</u> Quality, Efficiency, Partnerships, Improving Population Health, Per Capita Costs , Service**

“Uniting the Tribes”

McKethan

Community Care of North Carolina

- **Quality tribe**
- **Payment Reform tribe**
- **HIT tribe**
- **Consumerism tribe**

What about the provider tribes?

A Very Challenging Time Ahead for States!

- **2+ billion revenue deficit facing this session of the NC General Assembly**
- **Expiration of enhanced FMAP for Medicaid**
- **Continued growth in Medicaid rolls due to economy**
- **New Republican General Assembly who will be looking for solutions without raising taxes**
- **Major push by commercial Medicaid MCOs to do business in NC (will mean 15+% cut to hospitals)**
- **A panic on how to pay for 2014 Medicaid expansion**

Medicaid & Medicare Challenges

- Lowering reimbursement reduces access and increases ER usage/costs
- Reducing eligibility or benefits limited by federal “maintenance of effort”; raises burden of uninsured on community and providers
- The highest cost patients are also the hardest to manage (disabled, mentally ill, etc.) — CCNC has proven ability to address this challenge
- Utilization control and clinical management only successful strategy to reining in costs overall

Our Vision and Key Principles

Community Care of North Carolina

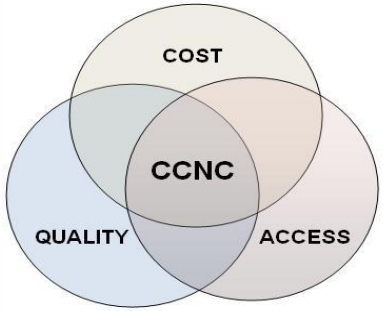
Develop a better healthcare system for NC starting with public payers

- **Strong Primary care is foundational to a high performing healthcare system**
- **Additional resources needed to help primary care manage populations**
- **Timely data is essential to success**
- **Must build local healthcare systems**
- **Physician leadership critical**
- **Improve the quality of the care provided and cost will come down**
- **A risk model is not essential to success- shared accountability is**

Key Tenets of Community Care

Community Care of North Carolina

- Public-private partnership
- “Managed not regulated”
- CCNC is a clinical partnership, not just a financing mechanism
- Community-based, physician-led medical homes
- Cut costs primarily by greater quality, efficiency
- Providers who are expected to improve care must have ownership of the improvement process



Primary Goals of Community Care

- Improve the care of the enrolled population while controlling costs
- A “medical home” for patients, emphasizing primary care
- Community networks capable of managing recipient care
- Local systems that improve management of chronic illness in both rural and urban settings

Community Care Provides NC with:

- Statewide medical home & population management system (care & disease management, acute and preventive care, etc) in place to address quality, utilization and cost
- 100 percent of all Medicaid savings remain in state
- A private sector Medicaid management solution that improves access and quality of care
- Medicaid savings that are achieved in partnership with – rather than in opposition to – doctors, hospitals and other providers.

Community Care: "How it works"

- Primary care medical home available to 1.1 million individuals in all 100 counties (Currently over 80,000 duals are enrolled).
- Provides 4,500 local primary care physicians(92% of all PCPs) with resources to better manage Medicaid population
- Links local community providers (health systems, hospitals, health departments and other community providers) to primary care physicians
- Every network provides local care managers (600), pharmacists (26), psychiatrists (14) and medical directors (20) to improve local health care delivery

How it works

Community Care of North Carolina

- The state identifies priorities and provides financial support through an enhanced PMPM payment to community networks
- Networks pilot potential solutions and monitor implementation (physician led)
- Networks voluntarily share best practice solutions and best practices are spread to other networks
- The state provides the networks access to data
- Cost savings/ effectiveness are evaluated by the state and third-party consultants (Mercer, Treo Solutions).

Community Care Networks

- Are non-profit organizations that receive a per member per month (PMPM) payment from the state
- Primary care providers also receive a PMPM payment
- Provides resources needed to manage enrolled population, reducing costs
- Central office of CCNC is also a nonprofit 501(c)(3)
- Seek to incorporate all providers, including safety net providers
- Have Medical Management Committee oversight
- Hire care management staff

Community Care Networks

Community Care of North Carolina

Legend

- AccessCare Network Sites
- AccessCare Network Counties
- Community Care of Western North Carolina
- Community Care of the Lower Cape Fear
- Carolina Collaborative Community Care
- Community Care of Wake and Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Carolina Community Health Partnership
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care
- Partnership for Health Management
- Community Care of the Sandhills
- Community Care of Southern Piedmont

Each network has:

- Clinical Director
  - A physician who is well known in the community
  - Works with network physicians to build compliance with care improvement objectives
  - Provides oversight for quality improvement in practices
  - Serves on the Sate Clinical Directors Committee
- Network Director who manages daily operations
- Care Managers to help coordinate services for enrollees/practices
- PharmD to assist with Med Mgt. of high cost patients
- Psychiatrist to assist in mental health integration

Current State-wide Disease and Care Management Initiatives

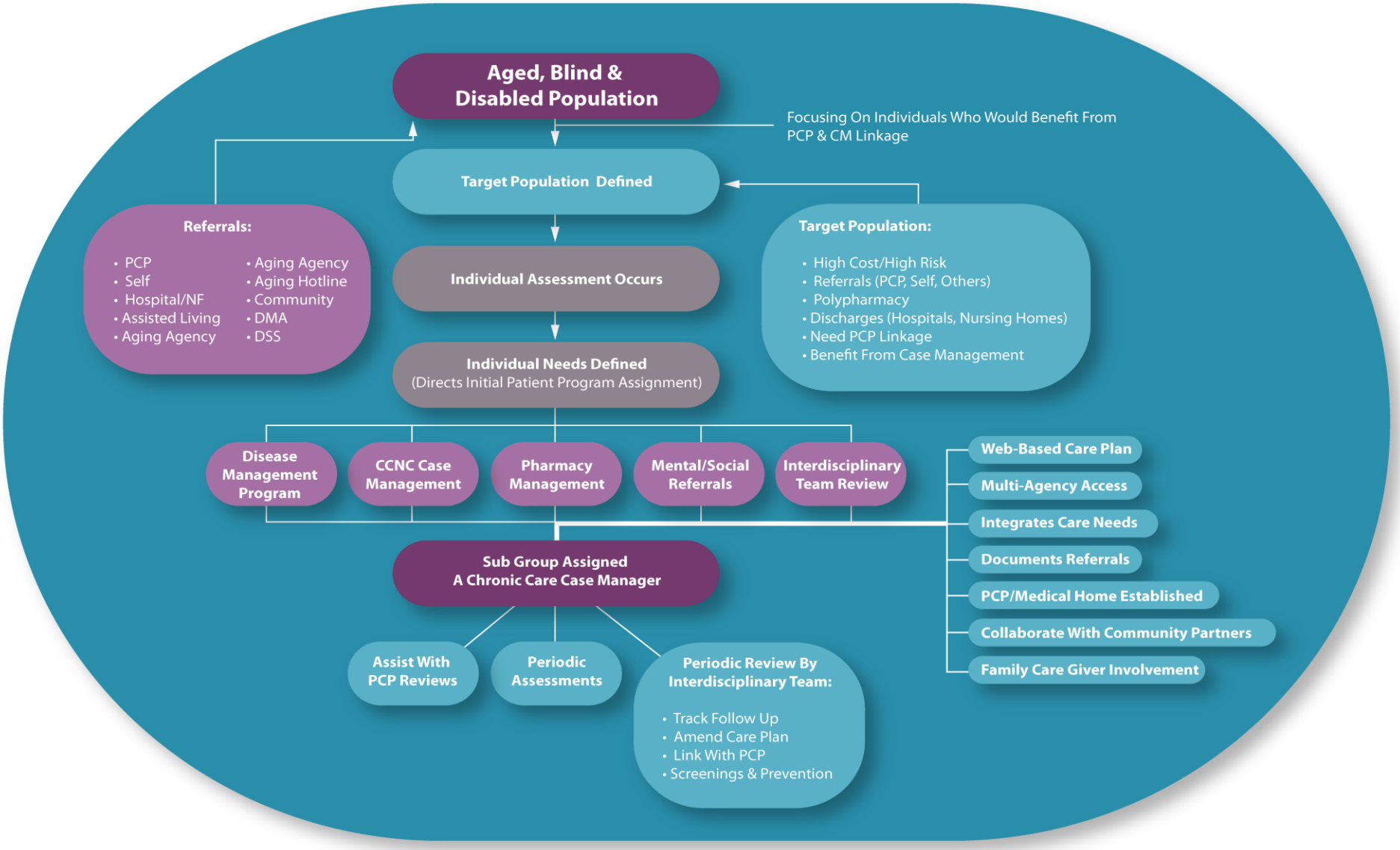
- **Asthma** (1998 – 1st Initiative)
- **Diabetes** (began in 2000)
- **Dental Screening and Fluoride Varnish** (piloted for the state in 2000)
- **Pharmacy Management**
  - Prescription Advantage List (PAL) - 2003
  - Nursing Home Poly-pharmacy (piloted for the state 2002 - 2003)
  - Pharmacy Home (2007)
  - E-prescribing (2008)
  - Medication Reconciliation (July 2009)
- **Emergency Department Utilization Management** (began with Pediatrics 2004 / Adults 2006)
- **Case Management of High Cost-High Risk** (2004 in concert with rollout of initiatives)
- **Congestive Heart Failure** (pilot 2005; roll-out 2007)
- **Chronic Care Program – including Aged, Blind and Disabled**
  - Pilot in 9 networks 2005 – 2007
  - Began statewide implementation 2008 - 2009
- **Behavioral Health Integration** (began fall 2010)
- **Palliative Care** (began fall 2010)
- **Pregnancy Medical Home** (began spring 2011)

CCNC's Statewide System – Critical Mass Exists Now

- **Capacity**
  - 14 not-for-profit regional networks
  - 4,500 primary care physicians (1,450 medical homes)
  - Local Health Departments
  - FCHCs and RHCs
  - All NC hospitals and Academic Medical Centers
- **Population**
  - 1.1 million+ Medicaid enrollees
  - 50,000 uninsured
  - 83,000 dual eligibles
  - SCHIP
- **Network Support Resources**
  - 600 care coordinators
  - 25 pharmacists
  - 15 psychiatrists
  - 22 local medical directors

Chronic Care Process

Community Care of North Carolina



Community Care's Informatics Center

Informatics Center — Medicaid claims data

- Utilization (ED, Hospitalizations)
- Providers (Primary Care, Mental Health, Specialists)
- Diagnoses – Medications – Labs
- Costs
- Individual and Population Level Care Alerts

Real-time data

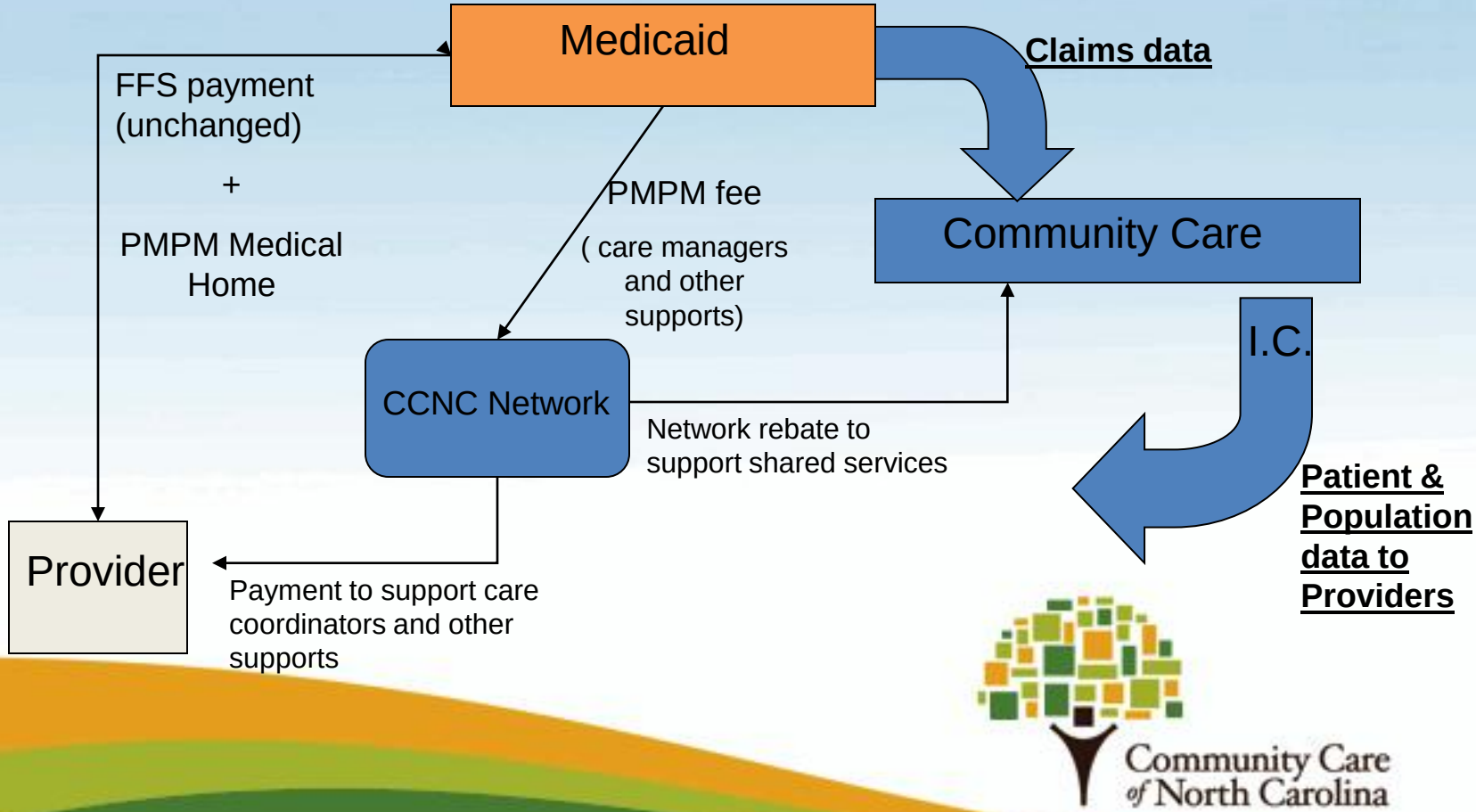
- Hospitalizations, ED visits, provider referrals

Community Care's Informatics Center

- Care Management Information System (CMIS)
- Pharmacy Home
- Quality Measurement and Feedback Chart Review System
- Informatics Center Reports on prevalence, high-opportunity patients, ED use, performance indicators
- Provider Portal

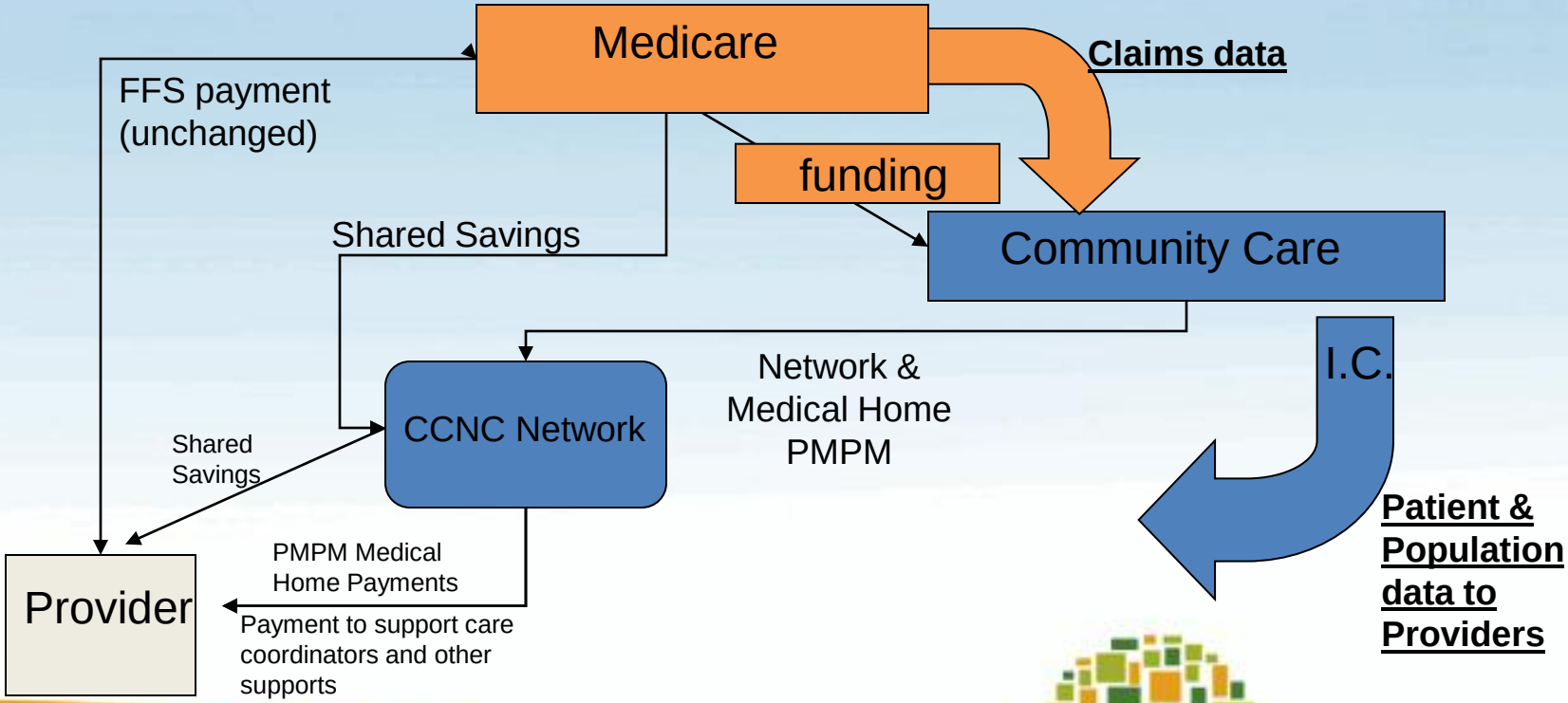
Provider Portal Demo

How CCNC Works with Medicaid



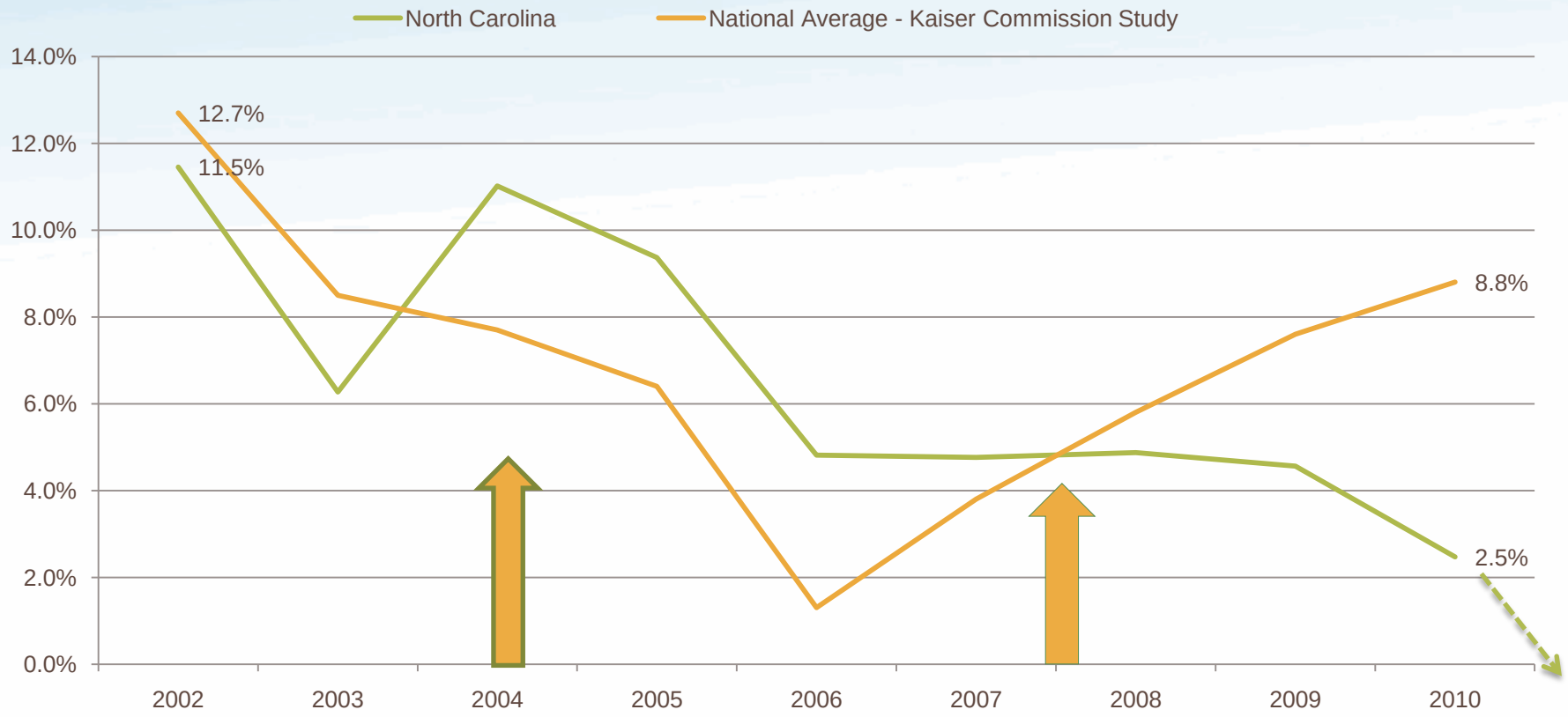
Community Care of North Carolina

How CCNC Works with Medicare (proposed)



Community Care of North Carolina

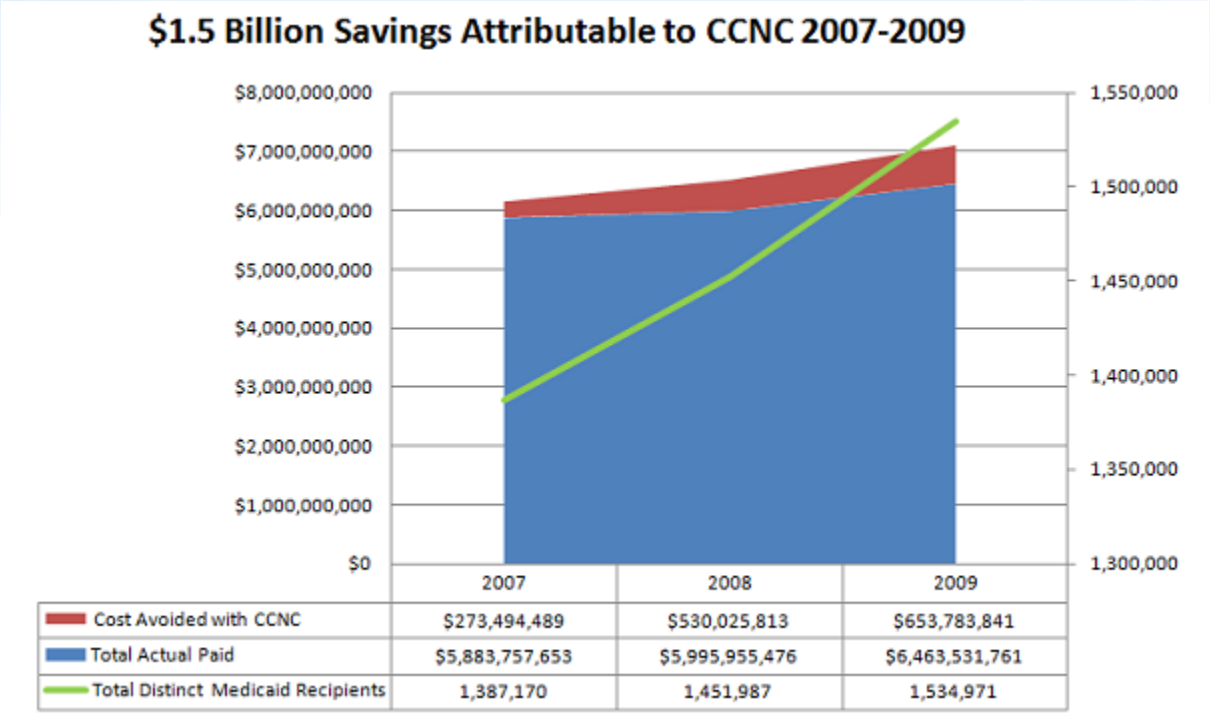
Evidence of Impact:
Annual Percent Change in Medicaid Expenditures
2002 - 2010



CCNC expands across North Carolina starting in 1998. Between 2002 and 2005 expansion increased from 17 to 93 counties. By 2007, all 100 counties were under the CCNC umbrella

CCNC Implements ABD Program

Financial results



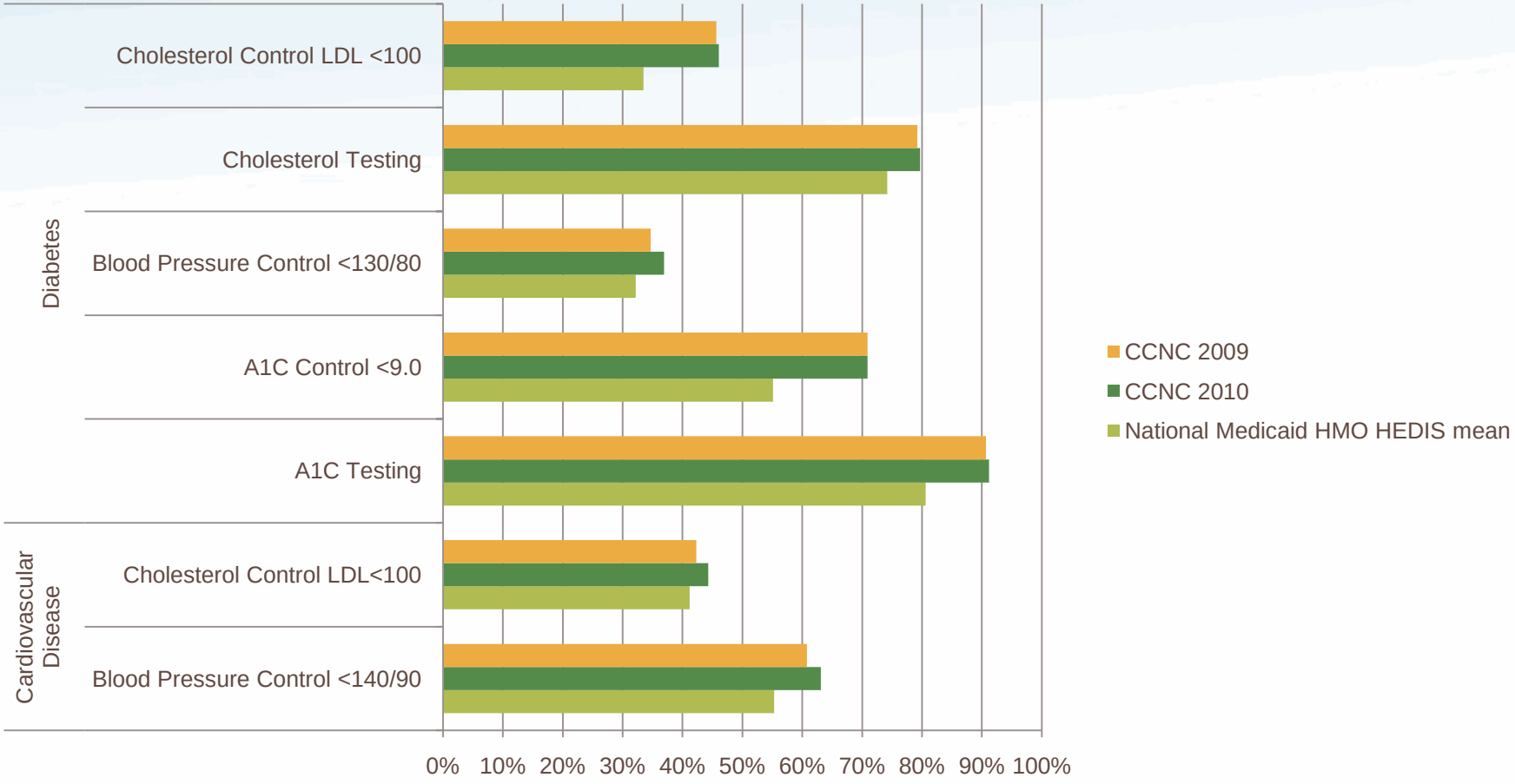
Using the unenrolled fee-for-service population, risk adjustments were made by creating a total cost of care (PMPM) set of weights by Clinical Risk Group (CRG), with age and gender adjustments. This weight set was then applied to the entire NC Medicaid Population. Using the FFS weight set and base PMPM, expected costs were calculated. This FFS expected amount was compared to the actual Medicaid spend for 2007, 2008, 2009. The difference between actual and expected spend was considered savings attributable to CCNC. Treo Solutions, Inc., June 2011.

Financial results

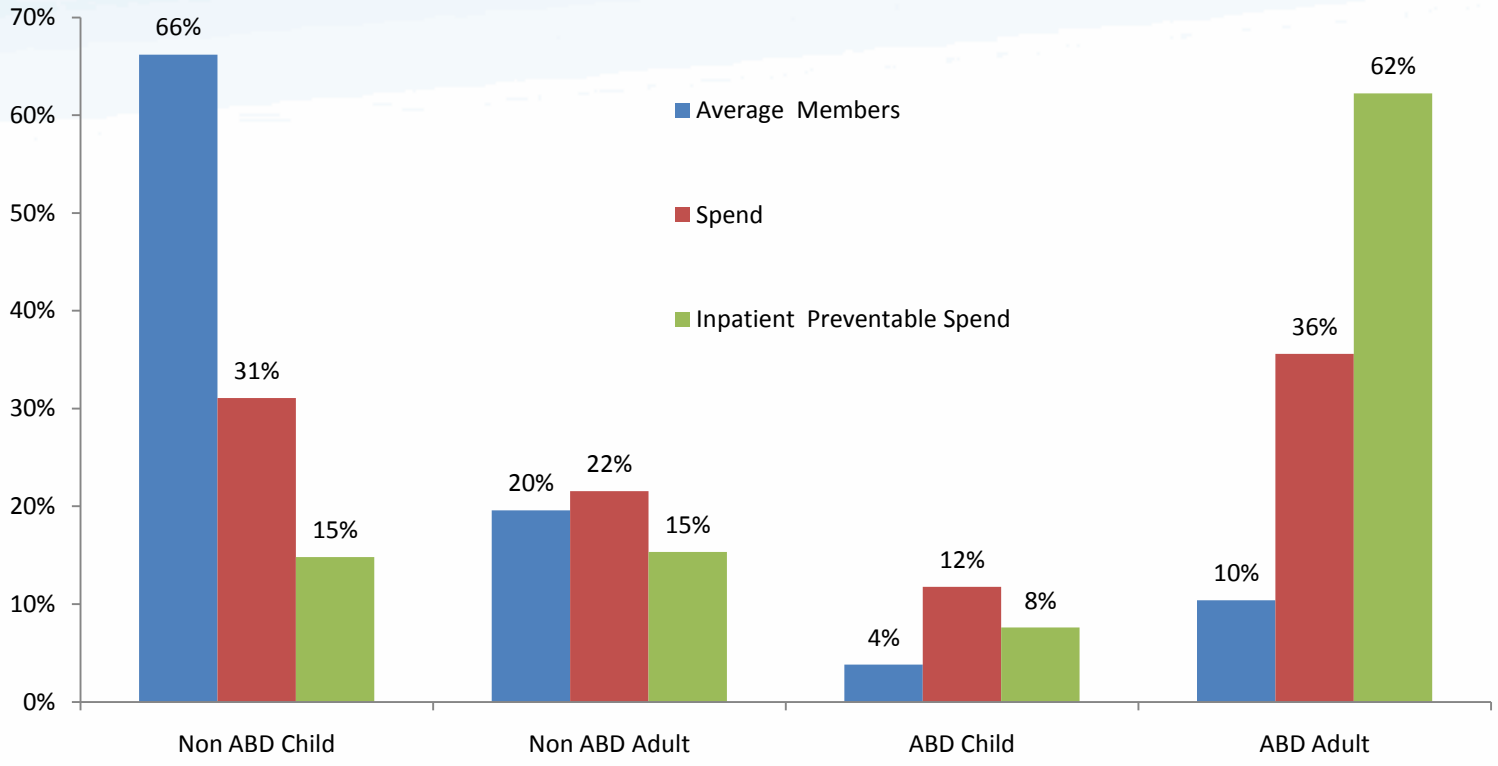
- **Earlier studies by Mercer, Inc. estimated CCNC savings as:**

State Fiscal Year	Estimated Savings
2005	$77 - $81M
2006	$154 - $170M
2007	$135 - $149M
2008	$156 - $164M
2009	$186 - $194M

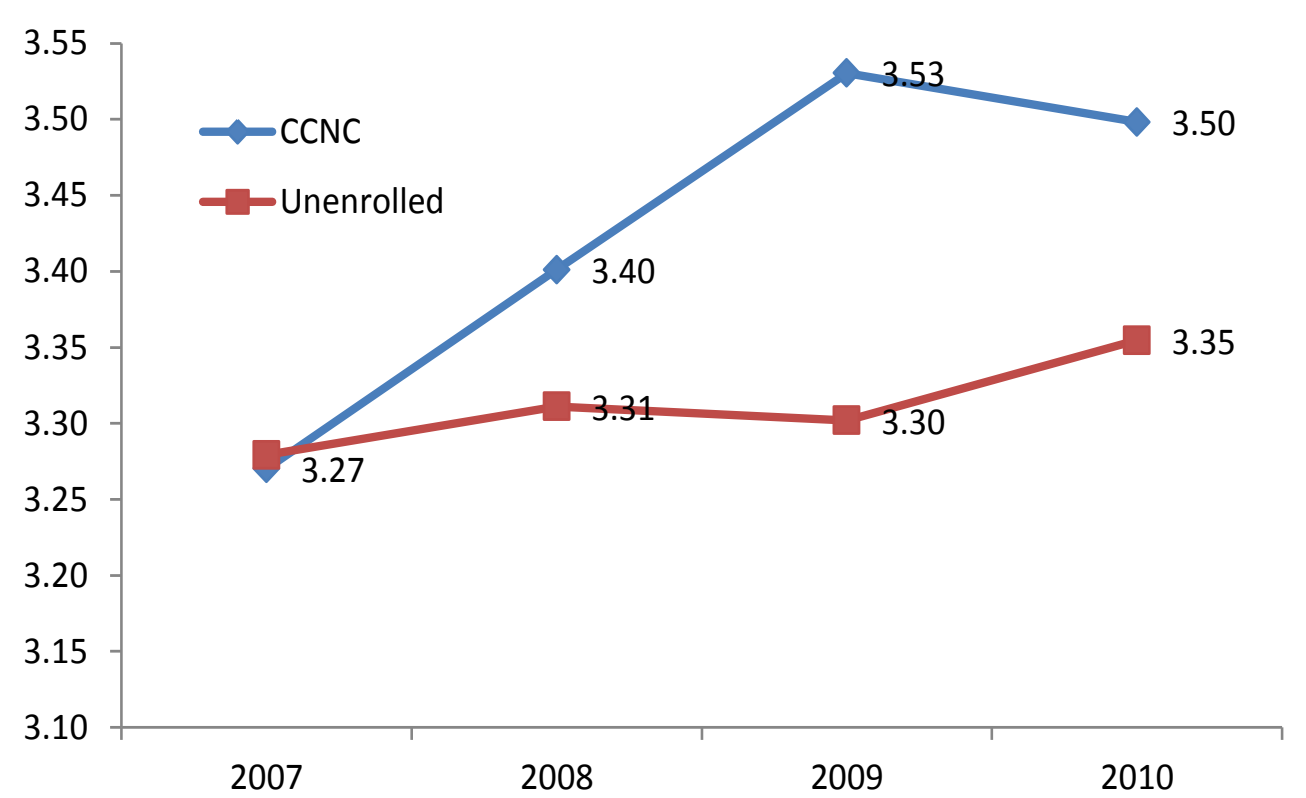
Quality HEDIS Measures



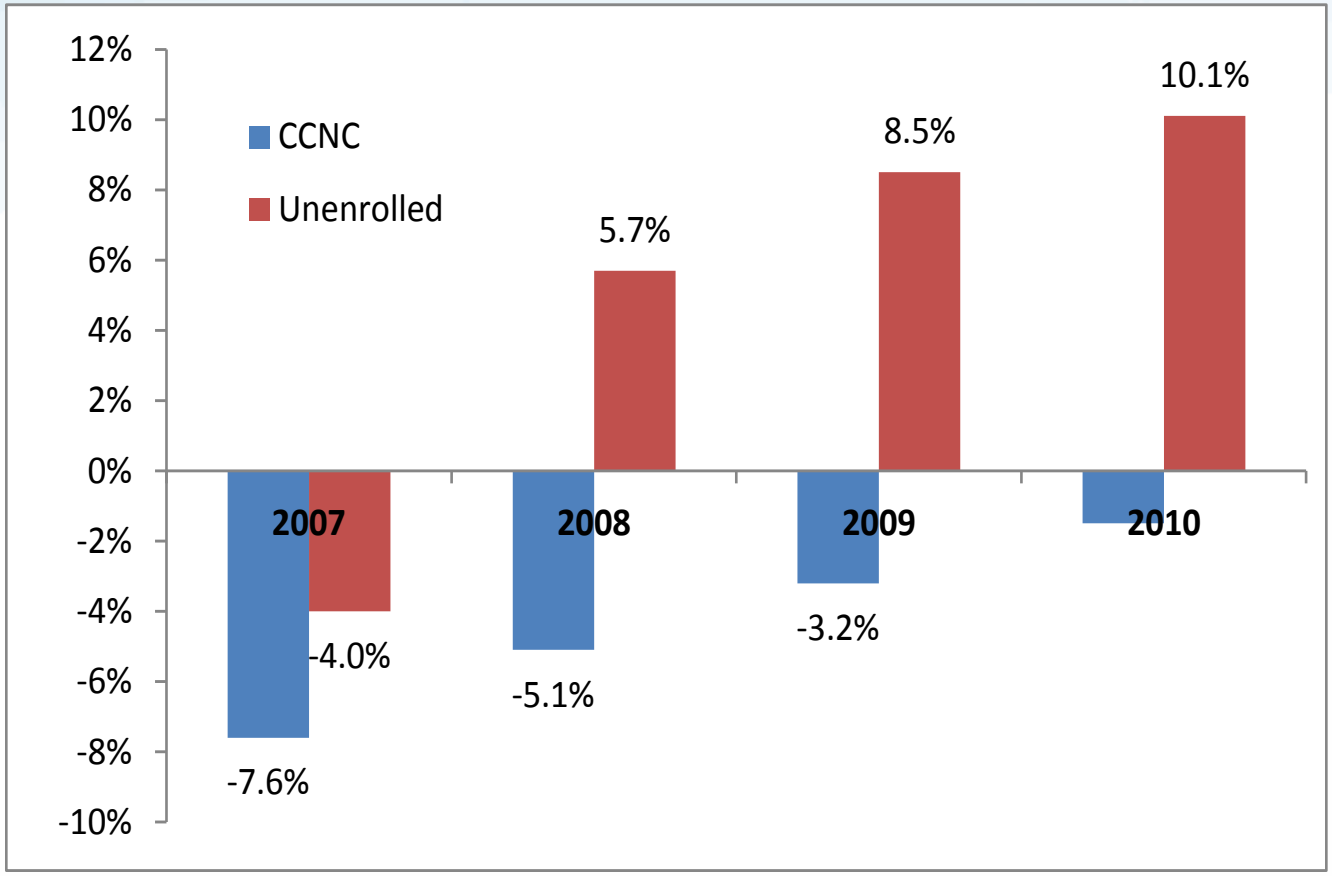
CCNC Data: Distribution of members and spend for SFY 2010:



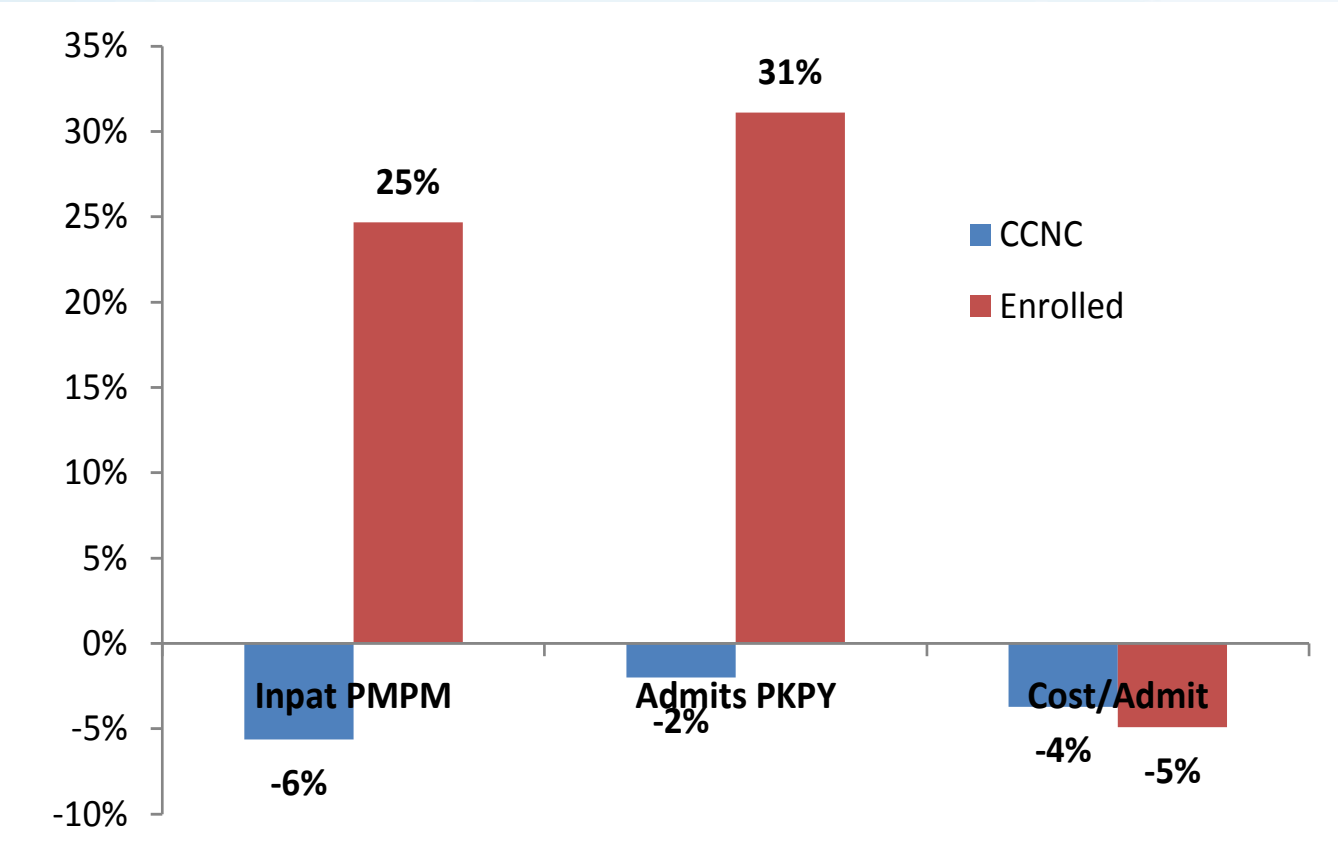
Risk scores of adult ABD Medicaid recipients, CCNC enrolled vs. unenrolled.



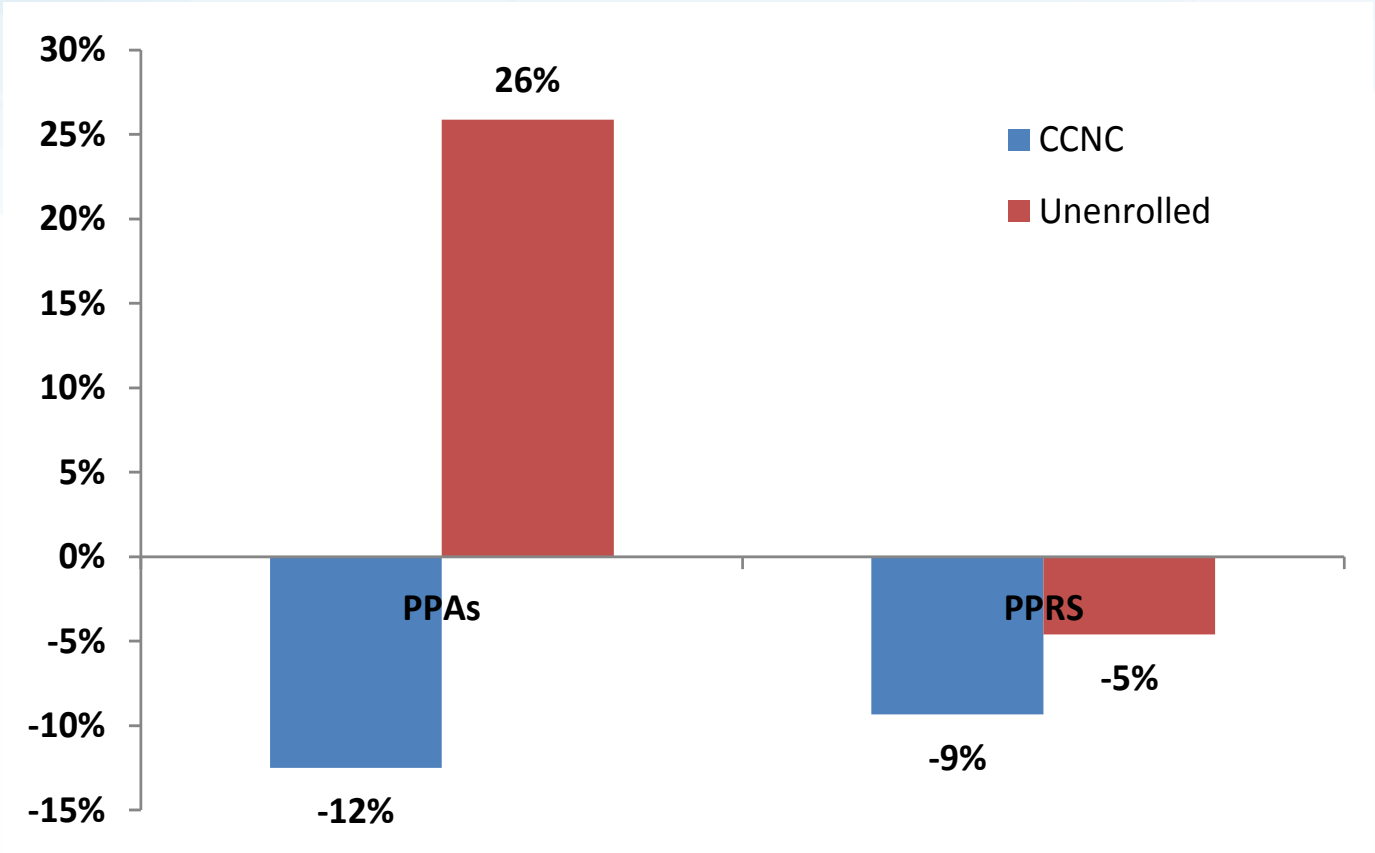
Actual versus expected costs for CCNC vs. unenrolled population



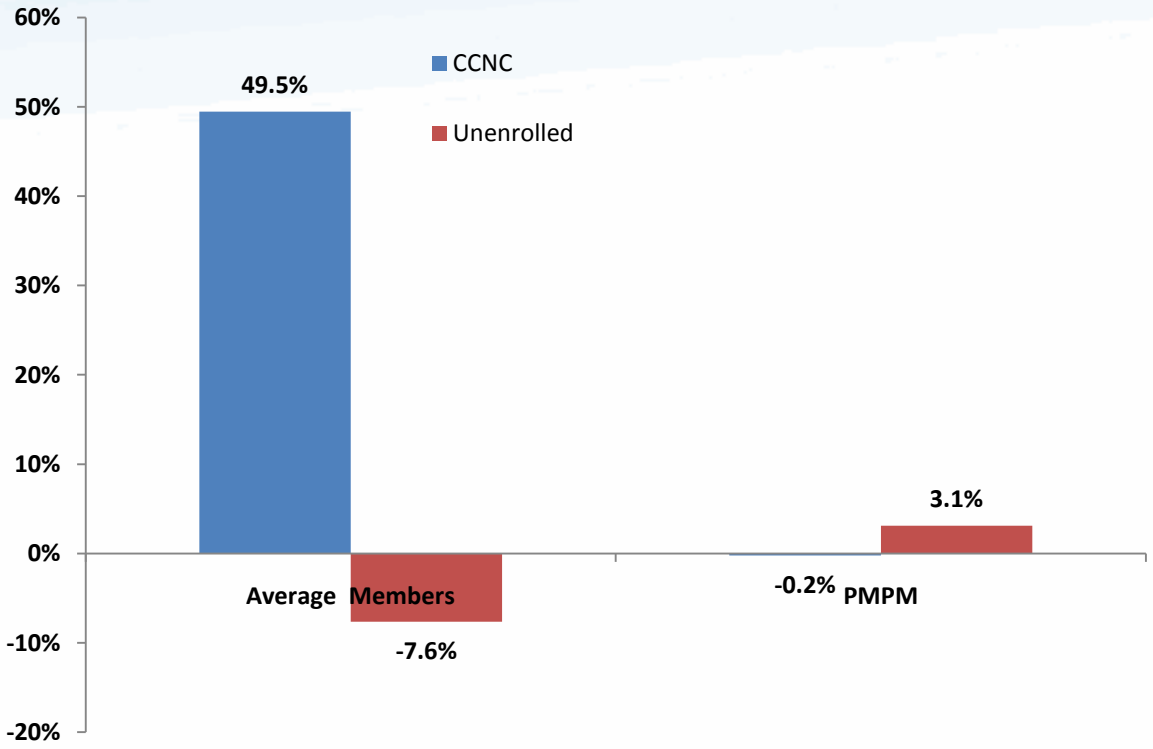
Four-year % Change for Adult ABD Population: Inpatient PMPM Spending, Inpatient Admissions Per Thousand members per year (PKPY), and cost per admission:



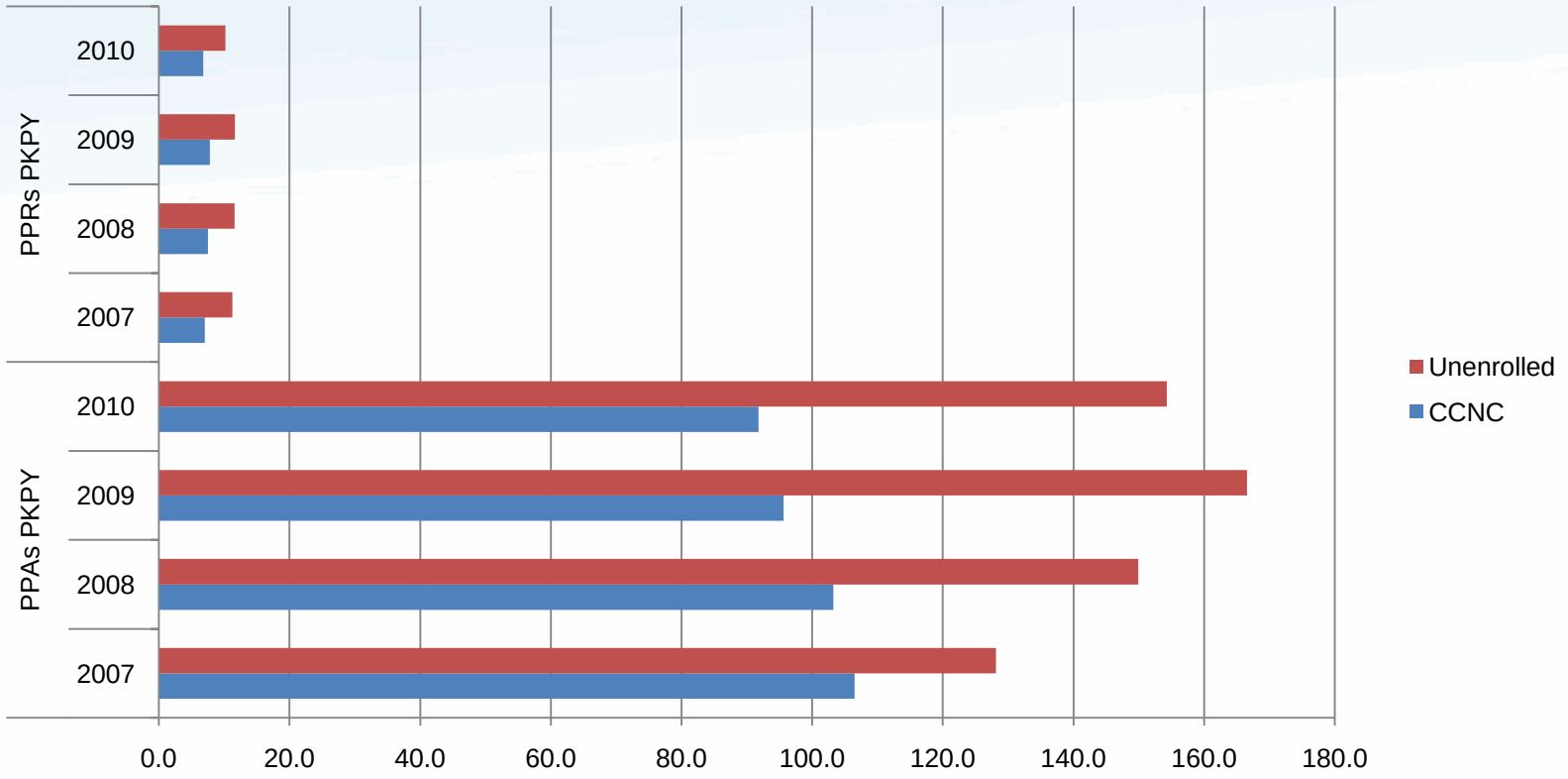
Four-year % Change for Adult ABD Population: Preventable Admissions, Readmissions PKPY



Four-year Trends in the Adult ABD Population with a Serious Chronic Mental Health Condition:

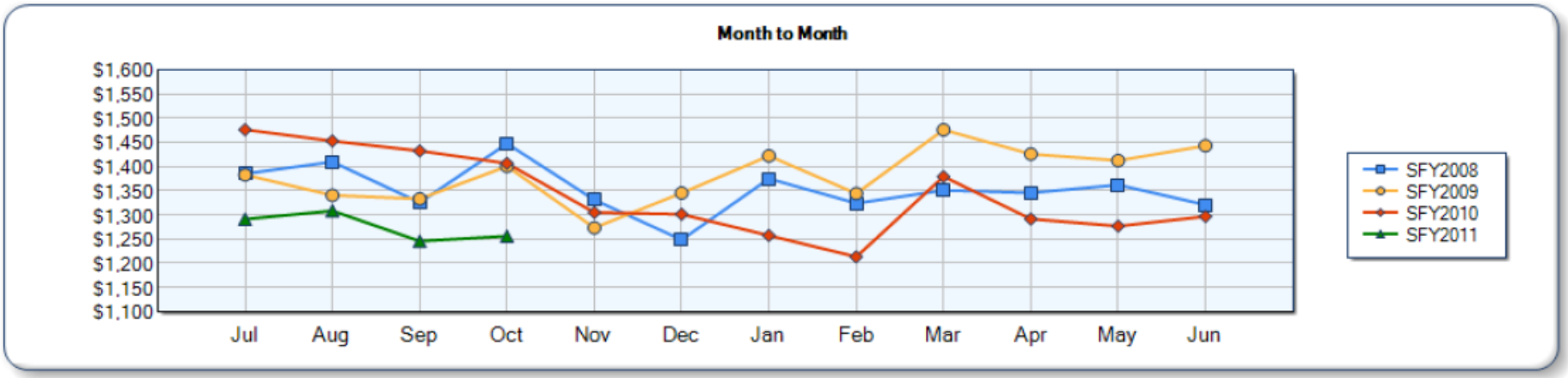


Preventable Admissions and Readmissions for adult ABD population chronic mental illness

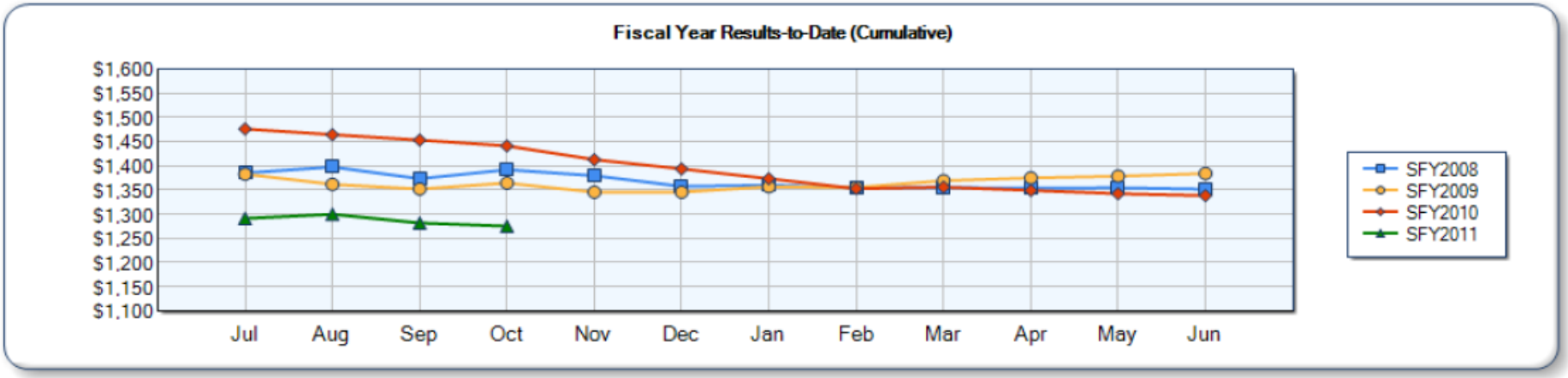


DHHS Performance Measures for CCNC

Enrolled Non-Dual ABD Cost PMPM



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	$1,385	$1,410	$1,325	$1,447	$1,331	$1,248	$1,375	$1,324	$1,351	$1,345	$1,362	$1,321
SFY2009	$1,383	$1,340	$1,333	$1,400	$1,273	$1,345	$1,422	$1,344	$1,476	$1,426	$1,412	$1,443
SFY2010	$1,476	$1,453	$1,432	$1,406	$1,305	$1,301	$1,257	$1,213	$1,379	$1,291	$1,277	$1,297
SFY2011	$1,291	$1,308	$1,246	$1,256	-	-	-	-	-	-	-	-



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	$1,385	$1,398	$1,373	$1,392	$1,379	$1,357	$1,360	$1,355	$1,355	$1,354	$1,355	$1,352
SFY2009	$1,383	$1,361	$1,352	$1,364	$1,345	$1,345	$1,356	$1,355	$1,369	$1,375	$1,379	$1,385
SFY2010	$1,476	$1,464	$1,453	$1,441	$1,413	$1,394	$1,374	$1,353	$1,356	$1,350	$1,343	$1,339
SFY2011	$1,291	$1,300	$1,281	$1,274	-	-	-	-	-	-	-	-

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Complementary CMS/DHHS Initiatives in NC

Community Care of North Carolina

Medicare related or focused:

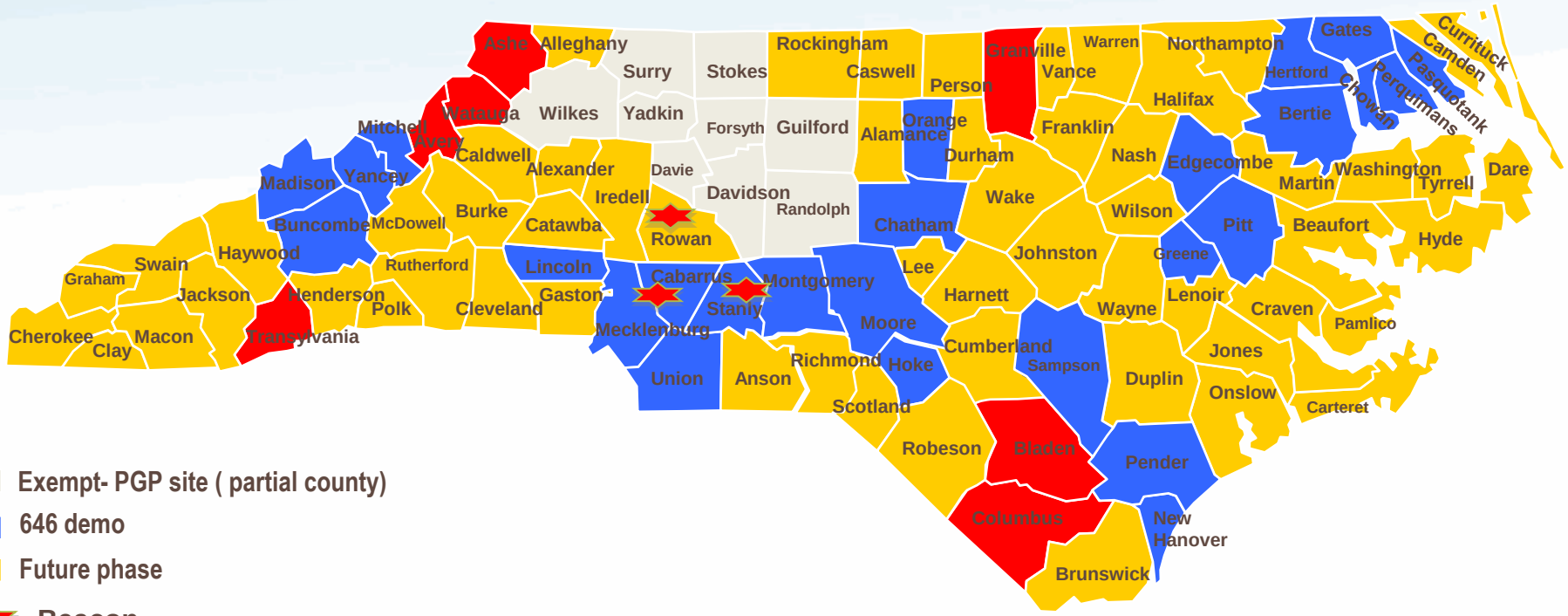
- 646 demo (CCNC)
- Dual eligible planning grant (DMA & CCNC)
- Multi-payer primary care demo (DMA/BCBS/State Health Plan/CCNC)

Increasing use of HIT and improving quality:

- Health Information Exchange (NCHIE)
- Regional Extension Center – NC AHEC
- Beacon Community – Southern Piedmont Community Care Plan/CCNC
- CHIPRA (CCNC)
- ONC challenge grant (HIE and CCNC)

Current CMS Initiatives

Community Care of North Carolina



- Exempt- PGP site (partial county)
- 646 demo
- Future phase
- Beacon
- Advanced multi-payer primary care demo

646 Medicare demo

- **5 yr began Jan 2010**
- **Quality Demonstration – must meet quality improvement**
- **Shared Saving model (non –risk)**
- **Yr 1 & 2 dually eligible Medicare and Medicaid recipients (42,000)**
- **Yr 3-5 option to add FFS Medicare (180,000)**

Multi-payer Advanced Primary Care Demonstration

Community Care of North Carolina

- **Partnership between NC Medicaid, CMS (Medicare), BCBS and State Health Plan**
- **3 yr demonstration beginning Oct 2011**
- **Improve quality and lower costs in rural underserved communities**
- **All payers provide additional support for PCPs ($2.50 pmpm) and local CCNC network ($2.50-8.00 pmpm)**
- **Attain medical home certification, lower ED rates, avoidable admissions, E prescribing, care coordination and improved chronic disease quality metrics**

Beacon Community

Community Care of North Carolina

- **$15 million ONC grant to Southern Piedmont Community Care network**
- **Build an all payer program to improve quality and lower costs using technology and enhanced medical home teams**
- **3 year grant (began April 2010)**

Dual eligible planning grant

- **$1 million to CCNC and DMA to work with stakeholders in designing a comprehensive to integrate care for dually eligiables**
- **Design improved care in facilities as well as home**

CHIRPA Grant

Community Care of North Carolina

- **Category A: Evaluate the Use of 24 new children quality measures**
- **Category C: evaluate provider based models to improve care in children on Medicaid/SCHIP focusing on children with special health care needs (4 networks and 11 practices)**
- **Category D: NC and PA working to define Children's Electronic Health Record**

ONC Challenge Grant

- **$ 1.7 million grant (NCHIE and CCNC)**
- **Build enhanced web based pharmacy home module**
- **Medication reconciliation and medication management**
- **Communication tools for pharmaicst, care managers and physiciains**

CCNC Network Structure

Existing, significant shared infrastructure (public-private partnership)

- Informatics Center and “central office” program support

Growing multi-payer capacity

- Major Medicare 646 demo (26 counties — 43,000 duals and 180,000 Medicare - 2012)
- Primary care multi-payer demo (7 rural counties — 150,000 patients)
- State Health Plan Medical Home Initiative
- Employer initiatives (First in Health- GSK and others)

Next Steps

- **More robust data systems to support effort**
- **Enroll specialists in CCNC**
- **State-wide Medicare initiative**
- **Build multi-payer capacity and support local provider systems (State Health Plan, BCBC, First in Health)**
- **Test shared savings models (invest in prevention)**
- **Collaboration with other states**

Lessons Learned

- **Primary Care is foundational**
- **Data essential (timely and patient specific)**
- **Additional community based resources to help manage populations needed (best is located in practice)**
- **Local networks builds local accountability and collaboration**
- **Physician leadership essential**
- **Must be flexible (healthcare is local)**
- **Make wise choices of initiatves (where you can make a difference- success breeds success)**

More information?

- **www.communitycarenc.org**